

# Transforming Health Care to Meet the Needs of Chronically Ill Patients

## Integrated Care Experiences and Outcomes in Germany, the Netherlands and England



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# Objectives of paper/ presentation (I)

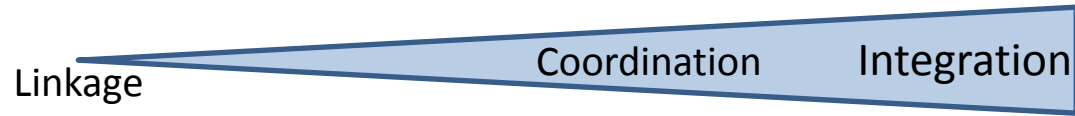
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- **Problem with systematic reviews:** they rely on already published papers = run well behind the latest developments.
- We therefore aim to:
  - (1) To take **a look at newer developments in European countries**, which are not yet included in systematic reviews;
  - (2) To explicitly address the role of **financial incentives**.

Separate provision

# Paying for care coordination

Full Integration



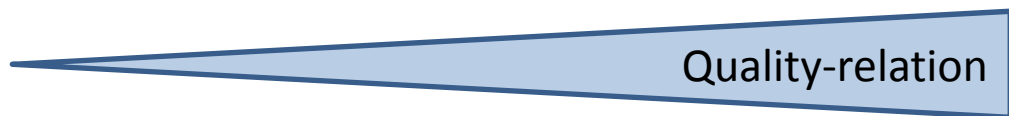
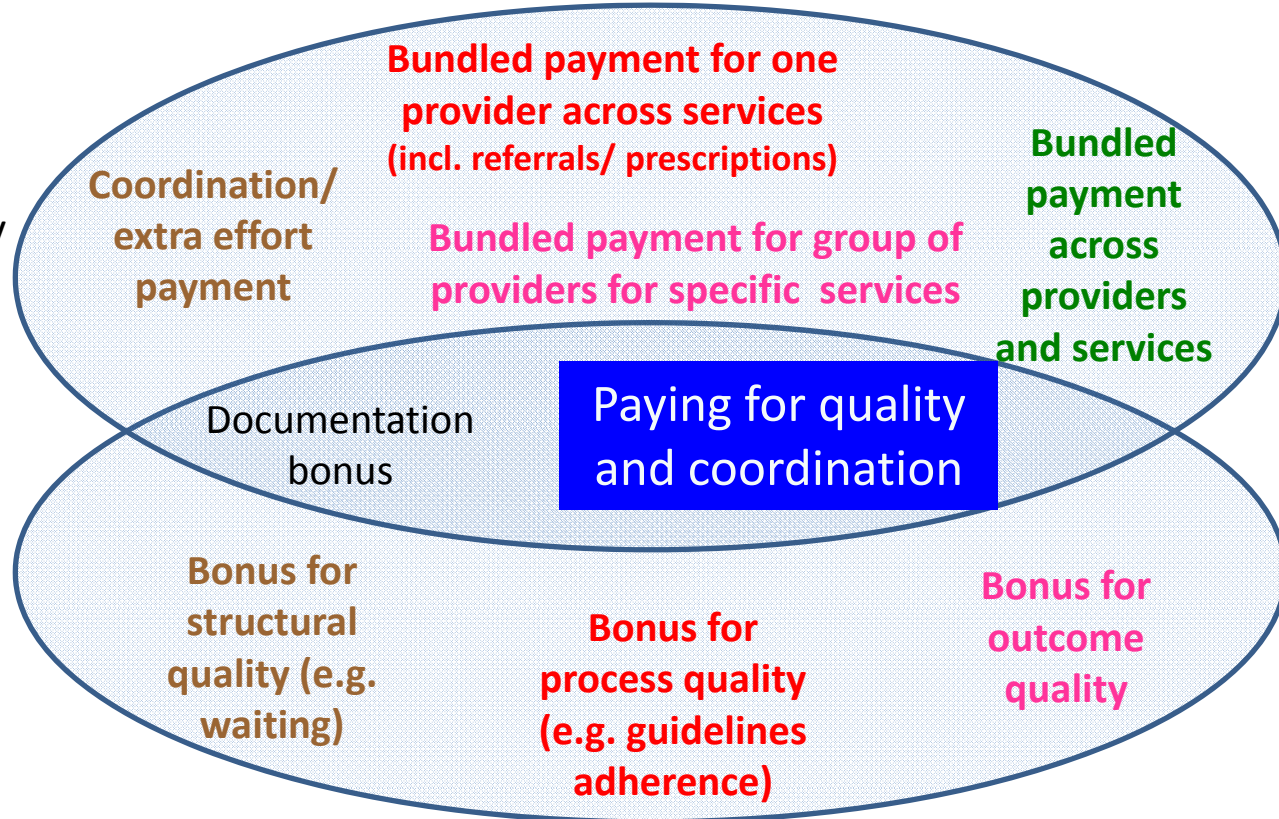
Capitation

and/or

or

Case-based

and



Structure

Process

Outcome

## Objectives of paper/ presentation (II)

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- **Problem with systematic reviews:** they rely on already published papers = run well behind the latest developments.
- We therefore aim:
  - (1) To take a **look at newer developments in European countries**, which are not yet included in systematic reviews;
  - (2) To explicitly address the role of **financial incentives**.
- We concentrate on **Germany, the Netherlands and the United Kingdom** with major developments over the last few years.
- We only look at approaches which have been **evaluated using control groups** (most often those not falling into an integrated care model, but rather continuing with care-as-usual) and, as far as possible, measurements **before and after the start of the intervention**.

# Our (admittedly simplified) model



	Primary prevention	GP care	Ambulatory specialist care	Ambulatory care by other providers	Secondary prevention	Accident & Emergency/ Emergency Room	Inpatient treatment	Rehabilitation	Continuing care	End-of-life care
“Healthy”										
Diabetes										
COPD										
Cardio-vasc. dis.										
Other chronic diseases										
Elderly in community										
Dementia										
Other mental health problems										
...										

Fragmentation all over, between different patients, sectors and institutions, within institutions etc.

# The German Kinzigtal approach

- Integrated care contracts possible since 2000
- Currently 1,600 contracts net with ca. 1.9 million patients
- But most of them limited to acute care/ rehabilitation etc.
- Kinzigtal (since 2006) exception: population-based
- Financial incentive: shared savings contract



	Primary prevention	GP care	Ambulatory specialist care	Ambulatory care by other providers	Secondary prevention	Accident & Emergency/ Emergency Room	Inpatient treatment	Rehabilitation	Continuing care	End-of-life care
“Healthy”	Variety of activities included: DMPs, case management, central electronic patient record, prevention programs, coaching of high-cost patients etc.									
Diabetes										
COPD										
Cardio-vasc. dis.										
Other chronic diseases										
Elderly in community										
Dementia										
Other mental health problems										
...										

# The Dutch bundled payment approach

- Since 2007 experiments with bundled payments
- Since 2010 “official” for diabetes, COPD & CVD, based on “care standards”
- Financial incentive: bundled payment to care group, covering all costs for particular indication, incl. other providers (*with incentive to shift costs to other indications*)

	Primary prevention	GP care	Ambulatory specialist care	Ambulatory care by other providers	Secondary prevention	Accident & Emergency/ Emergency Room	Inpatient treatment	Rehabilitation	Continuing care	End-of-life care
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# The English Integrated Care Pilots approach



- 2008 “Equity and Excellence: Liberating the NHS”
- Call and selection of 16 Integrated Care Pilots (2009) with different foci “to achieve more personal, responsive care and better health outcomes for local population”
- Since 2011, also North West London Integrated Care Pilot
- Financial incentive: not really

	Primary prevention	GP care	Ambulatory specialist care	Ambulatory care by other providers	Secondary prevention	Accident & Emergency/ Emergency Room	Inpatient treatment	Rehabilitation	Continuing care	End-of-life care
“Healthy”										
Diabetes		Red						Yellow		Blue
COPD		Brown								Blue
Cardio-vasc. dis.										Blue
Other chronic diseases										Blue
Elderly in community		Green						Yellow		Blue
Dementia		Pink								Blue
Other mental health problems										Blue
...										Blue





# Results at a glance (sorry for over-simplifying)

		Patient				Experience of healthcare providers	Costs
		Intermediate clinical outcomes and mortality	Hospital care utilization	Process indicators	Patient experience		
<b>D</b>	Healthy Kinzigtal Integrated Care	Mortality ↓ (1.76% vs. 3.74%)			Change of insurer ↓	Cooperation ↑	- US\$ 203
<b>N</b>	Bundled payment system		Specialist care ↓	4 check-ups ↑; foot/ kidney exams ↑; eye testing ↓	“Cooperation & coordination for diabetes excellent”	Perceived quality ↑; patient-centredness ↑	+ US\$ 388
<b>U</b> <b>K</b>	6 pilots		Admissions: emergency ↑; elective ↓		Care plans/ follow-up ↑; listening/ preferences ↓	Teamwork ↑; communication ↑; job depth/ breadth ↑	- US\$ 358
	11 pilots						
	16 pilots						
	North west London			Care plans ↑; diabetes testing ↑	“good idea, but no actual change”	Inter-professional learning & collaboration ↑ but “time-consuming”	

- The **results** in these three countries are almost as **mixed** as those found in the systematic reviews discussed by Nolte and Pitchforth (2013).
- The German **Kinzigtal** experience with its **broad scope** (both in terms of population included as well as services offered) and **clear financial incentives** should be an especially **worthwhile starting point** for future models both in Europe and in the United States.

Slides available at: [www.mig.tu-berlin.de](http://www.mig.tu-berlin.de)